



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Angela Skrabanek, OTR

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-3000-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 31, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "1: the Astrand-Rhyming test has been used for cardio-respiratory fitness Is the most difficult:

The patient is asked to pedal at 18 km per hour or 11.18 miles per hour.

The work load (KPM) is increased until patients' heart rate (HR) is between 120 and 170 beats per min.

According to any physical fitness requirement this HR is very high indeed.

**2: Single Stage Treadmill:**

The injured worker must walk at 2 to 5 miles per hour *without* using hand rails for 4 minutes.

They then must walk the same speed for an additional 4 minutes while the treadmill inclines at 5 degrees.

This test states that "*the person must not be allowed to support themselves by handrails in any manner except momentarily to maintain balance.*" ...

If an injured worker cannot meet either of these requirements there is a simpler, easier test that can help gauge their fitness without the undo strain of the above tests. This is the KASCH step test that is used at Harvard and in many PT/OT and other rehabilitation facilities. Ms. Skrabanek, OT, in her professional opinion and experience chose to test with this method. When reimbursement was denied, she did a detailed explanation of why she chose this method and was still denied reimbursement."

**Amount in Dispute:** \$846.24

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "... the provider's original request for reconsideration did not contain details of a single stage treadmill cardiovascular endurance test. The provider appears to have submitted detailed a FCE report listing cardiovascular endurance test with a treadmill with the MFDR paperwork (page 13 of 30) after the first reconsideration was processed."

**Response Submitted by:** Texas Mutual Insurance Company

## ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2015	Functional Capacity Evaluation (16 units)	\$846.24	\$846.24

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - A07 – Documentation does not meet the level of service required for FCE per Rule 134.204(g)(3)(C).
  - CAC-150 – Payer deems the information submitted does not support this level of service.
  - CAD-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
  - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 891 – No additional payment after reconsideration.
  - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

### **Findings**

1. The requestor is seeking reimbursement for a Functional Capacity Evaluation. The insurance carrier argues that "The original FCE documentation submitted on 6/17/15 (page 18 of 20) indicates a 'KASCH STEP TEST' was used as cardiovascular method. The FCE report (page 15) submitted on 7/29/15 with the request of reconsideration also listed the 'KASCH STEP TEST' was used as the Cardiovascular method."

28 Texas Administrative Code §134.204(g)(3)(C) states that an FCE shall include "submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill."

Review of the submitted information finds documentation dated June 15, 2015, that states that "THE SINGLE STAGE SUBMAXIMAL TREADMILL WALKING TEST WAS ATTEMPTED AND PARTIALLY COMPLETED. THIS TEST WAS TERMINATED AFTER 7 MINUTES AS PATIENT WAS NOT ABLE TO CONTINUE WALKING AT THE SPEED HE BEGAN WITH THE 5% REQUIRED INCLINE BEFORE HIS HR EXCEEDED 85% OF ITS MAX; THIS WAS CAUSE FOR TERMINATION OF TEST." While the insurance carrier provided an affidavit attesting that the treadmill documentation was not present in the records submitted with billing, the division notes that this documentation is present in documentation timely submitted with the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)(2)(M). The division finds that documentation submitted by the requestor indicates that the submaximal cardiovascular endurance test, known as the KASCH step test, was performed in **addition** to the abbreviated treadmill activity.

For the reasons listed above, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.204(g) states, in relevant part,

FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test.

Procedure code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." Review of the submitted documentation finds that the requestor documented that the test started at 9:30 AM and ended at 1:30 PM for a total of four hours, or 16 units. No evidence of previous FCE was found. For that reason, all 16 units billed can be considered for payment.

Applicable 28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For CPT code 97750-FC at the requestor's locality on June 15, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.459. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.006 is 0.463. The malpractice (MP) RVU of 0.02 multiplied by the MP GPCI of 0.955 is 0.019. The sum of 0.941 is multiplied by the Division conversion factor of \$56.20 for a total of \$52.89. This total is multiplied by 16 units for a MAR of \$846.24.

3. The total MAR for the disputed services is \$846.24. The insurance carrier paid \$0.00. A reimbursement of \$846.24 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$846.24.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$846.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 29, 2016  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**